Corrected by IC 2005-10

DEPARTMENT OF SOCIAL AND HEALTH SERVICES
MEDICAL ASSISTANCE ADMINISTRATION
Olympia, Washington

To: Neurodevelopmental Centers
Managed Care Plans

Memorandum No: 05-52 MAA
Issued: June 28, 2005

From: Douglas Porter, Assistant Secretary
Medical Assistance Administration (MAA)

For Information Call:
(800) 562-6188

Supersedes # Memorandum:
04-92, 04-43

Subject: Neurodevelopmental Centers: Fee Schedule Changes

Effective for dates of service on and after July 1, 2005, the Medical Assistance Administration (MAA) will implement:

- The updated Medicare Physician Fee Schedule Data Base (MPFSDB) Year 2005 relative value units (RVUs);
- Additions of Current Procedural Terminology (CPT™) codes; and
- One (1.0) percent vendor rate increase.

Maximum Allowable Fees

MAA is updating the Neurodevelopmental Centers fee schedule with Year 2005 RVUs. The 2005 Washington State Legislature appropriated a vendor rate increase of one (1.0) percent for the 2006 state fiscal year. The maximum allowable fees have been adjusted to reflect these changes.

Attached are updated replacement pages 9–38 for MAA's current *Neurodevelopmental Centers Billing Instructions*.

Bill MAA your usual and customary charge.

Added Procedure Codes

The following procedure codes have been added to the Occupational Therapy (OT) Program.

Procedure Code	Brief Description	July 1, 2005 Maximum Allowable	
		Non Facility Setting	Facility Setting
97004	OT Re-evaluation	$29.52	$18.40
97150	Group therapeutic procedure	10.45	10.45

Diagnosis Reminders

MAA requires valid and complete ICD-9-CM diagnosis codes. When billing MAA, use the highest level of specificity (4th or 5th digits if necessary) or the entire claim will be denied.

MAA's Provider Issuances

To view and download MAA's numbered memoranda and billing instructions electronically, visit MAA's website at http://maa.dshs.wa.gov (select the *Billing Instructions/Numbered Memoranda* link).

To request a free paper copy from the Department of Printing:

1. **Go to: http://www.prt.wa.gov/** (Orders filled daily).

   a) Click ***General Store***.

   b) If a **Security Alert** screen is displayed, click **OK.**

      i. Select either ***I'm New*** or ***Been Here***.
      ii. If new, fill out the registration and click ***Register***.
      iii. If returning, type your email and password and then click ***Login***.

   c) At the **Store Lobby** screen, click ***Shop by Agency***. Select ***Department of Social and Health Services*** and then select ***Medical Assistance.***

   d) Select ***Billing Instructions, Forms, Healthy Options, Numbered Memo, Publications,*** or ***Issuance Correction***. You will then need to select a year and the select the item by number and title.

2. **Fax/Call:** Dept. of Printing/Attn: Fulfillment at FAX (360) 586-6361/ telephone (360) 586-6360. (Orders may take up to 2 weeks to fill.)

Audiology

Who is eligible to perform audiology services? [WAC 388-545-0700 (1)(c)]

An audiologist who is appropriately licensed or registered to perform audiology services within their state of residence.

What type of equipment must be used?

Audiologists must use yearly calibrated electronic equipment, according to RCW 18.35.020.

Occupational Therapy

Who is eligible to provide occupational therapy? [Refer to WAC 388-545-0300(1)]

• A licensed occupational therapist;
• A licensed occupational therapy assistant supervised by a licensed occupational therapist; or
• An occupational therapy aide, in schools, trained and supervised by a licensed occupational therapist.

Fee Schedule

☞ **Note:** A program unit is based on the CPT® code description. If the description does not include time, the procedure equals one unit, regardless of how long the procedure takes.

If time is included in the CPT code description the beginning and ending times of each therapy modality must be documented in the client's medical record.

Due to its licensing agreement with the American Medical Association, MAA publishes only official, brief CPT code descriptions. To view the full descriptions, please refer to your current CPT book.

PHYSICAL THERAPY

Procedure Code	Brief Description	July 1, 2005 Maximum Allowable Fee	
		Non Facility Setting	Facility Setting
Tens Application			
64550	Apply neurostimulator	$10.67	$5.45
Muscle Testing (The maximum allowable is for payment in full, regardless of time required.)			
95831	Limb muscle testing, manual	17.26	9.54
95832	Muscle testing manual	14.53	9.77
95833	Body muscle testing, manual	24.53	16.35
95834	Body muscle testing, manual	28.84	20.67
95851	Range of motion measurements	12.04	5.68
95852	Range of motion measurements	8.63	3.86

Physical Therapy (cont.)

Procedure Code	Brief Description	July 1, 2005 Maximum Allowable Fee	
		Non Facility Setting	Facility Setting
Modalities			
97010	Hot or cold packs therapy	Bundled	Bundled
97012	Mechanical traction therapy	$8.86	$8.86
97014	Electrical stimulation therapy	8.63	8.63
97016	Vasopneumatic device therapy	8.40	8.40
97018	Paraffin bath therapy	3.86	3.86
97020	Microwave therapy	2.95	2.95
97022	Whirlpool therapy	8.86	8.86
97024	Diathermy treatment	3.18	3.18
97026	Infrared therapy	2.95	2.95
97028	Ultraviolet therapy	3.63	3.63
(For the procedures listed below, the therapy provider is required to be in constant attendance.)			
97032	Electrical stimulation	9.54	9.54
97033	Electrical current therapy	12.26	12.26
97034	Contrast bath therapy	8.40	8.40
97035	Ultrasound therapy	7.27	7.27
97036	Hydrotherapy	13.85	13.85
97039	Physical therapy treatment	7.04	7.04

Physical Therapy (cont.)

Procedure Code	Brief Description	July 1, 2005 Maximum Allowable Fee	
		Non Facility Setting	Facility Setting
Therapeutic Procedures (Therapy provider is required to be in constant attendance.)			
97110	Therapeutic exercises	$16.81	$16.81
97112	Neuromuscular re-education	17.71	17.71
97113	Aquatic therapy/exercises	19.30	19.30
97116	Gait training therapy	14.76	14.76
97124	Massage therapy	13.40	13.40
97139	Physical medicine procedure	9.54	9.54
97140	Manual therapy	15.90	15.90
97150	Group therapeutic procedure	10.45	10.45
97504	Orthotic training	18.40	18.40
97520	Prosthetic training	16.81	16.81
97530	Therapeutic activities	17.71	17.71
97535	Self care mngment training	18.17	18.17
97537	Community/work reintegration	16.35	16.35
97542	Wheelchair mngment training	Not Covered	
97545	Work hardening	Not Covered	
97546	Work hardening add-on	Not Covered	
97597	Active wound care/20 cm or <	29.30	29.30
97598	Active wound care > 20 cm	37.47	37.47
97602	Wound care non-selective	19.53	19.53
97605	Neg press wound tx, < 50 cm	Bundled	Bundled
97606	Neg press wound tx, > 50 cm	Bundled	Bundled

PHYSICAL THERAPY (cont.)

Procedure Code	Brief Description	July 1, 2005 Maximum Allowable Fee	
		Non Facility Setting	Facility Setting
Tests and Measurements			
97001	Pt evaluation	$45.65	$38.61
97002	Pt re-evaluation	24.30	19.30
97005	Athletic evaluation	Not Covered	
97006	Athletic re-evaluation	Not Covered	
97703	Prosthetic checkout	15.44	15.44
97750	Physical performance test	17.94	17.94
97755	Assistive technology assessment	20.89	20.89
Other Procedures			
97532	Cognitive skills development	Not Covered	
97533	Sensory integration	Not Covered	
97799	Unlisted physical medicine rehabilitation service or procedure	By Report	

TEAM CONFERENCES

Procedure Code	Brief Description	July 1, 2005 Maximum Allowable Fee	
		Non Facility Setting	Facility Setting
99361	Physician/team conference	$40.88	$28.39
99362	Physician/team conference	72.22	56.78

PEDIATRIC EVALUATION

Procedure Code/ Modifier	Brief Description	July 1, 2005 Maximum Allowable Fee	
		Non Facility Setting	Facility Setting
New Patient			
99201	Office/outpatient visit, new	$33.52	$21.77
99202	Office/outpatient visit, new	59.79	42.85
99203	Office/outpatient visit, new	88.82	66.01
99204	Office/outpatient visit, new	125.45	97.80
99205	Office/outpatient visit, new	158.63	129.95
Established Patient			
99211	Office/outpatient visit, est	20.04	8.29
99212	Office/outpatient visit, est	35.60	22.12
99213	Office/outpatient visit, est	48.38	32.49
99214	Office/outpatient visit, est	75.69	53.91
99215	Office/outpatient visit, est	109.90	86.40

Note: Use modifier HA with CPT codes 99201-99215 to receive higher reimbursement for these services when using the parent's PIC to bill for services for an infant who has not received his or her own PIC.

Modifier HA: Child/adolescent program

SPEECH THERAPY

Procedure Code/ Modifier	Brief Description	July 1, 2005 Maximum Allowable Fee	
		Non Facility Setting	Facility Setting
Audiologists and Speech-Language Pathologists			
92506	Speech/hearing evaluation	$79.94	$29.30
92507	Speech/hearing therapy	37.93	17.49
92508	Speech/hearing therapy	17.94	8.86
92510	Rehab for ear implant	83.57	54.50
92551	Pure tone hearing test, air	10.28	10.28
97532	Cognitive skills development	14.76	14.76
97533	Sensory integration	15.67	15.67
Audiologists Only			
69210	Remove impacted ear wax	29.30	20.21
92541	Spontaneous nystagmus test	33.61	33.61
92541-TC	Spontaneous nystagmus test	19.76	19.76
92541-26	Spontaneous nystagmus test	13.85	13.85
92542	Positional nystagmus test	34.29	34.29
92542-TC	Positional nystagmus test	22.94	22.94
92542-26	Positional nystagmus test	11.36	11.36
92543	Caloric vestibular test	15.90	15.90
92543-TC	Caloric vestibular test	12.26	12.26
92543-26	Caloric vestibular test	3.63	3.63
92544	Optokinetic nystagmus test	27.25	27.25
92544-TC	Optokinetic nystagmus test	18.40	18.40
92544-26	Optokinetic nystagmus test	8.86	8.86
92545	Oscillating tracking test	24.30	24.30
92545-TC	Oscillating tracking test	16.35	16.35
92545-26	Oscillating tracking test	7.95	7.95
92546	Sinusoidal rotational test	52.91	52.91
92546-TC	Sinusoidal rotational test	43.15	43.15

Speech Therapy (cont.)

Procedure Code/ Modifier	Brief Description	July 1, 2005 Maximum Allowable Fee	
		Non Facility Setting	Facility Setting
Audiologists Only (cont.)			
92546-26	Sinusoidal rotational test	$9.77	$9.77
92547	Supplemental electrical test	2.95	2.95
92552	Pure tone audiometry, air	10.90	10.90
92553	Audiometry, air & bone	16.35	16.35
92555	Speech threshold audiometry	9.54	9.54
92556	Speech audiometry, complete	14.31	14.31
92557	Comprehensive hearing test	29.75	29.75
92567	Tympanometry	13.17	13.17
92568	Acoustic reflex test	9.54	9.54
92569	Acoustic reflex decay test	10.22	10.22
92579	Visual audiometry (VRA)	17.94	17.94
92582	Conditioning play audiometry	17.94	17.94
92584	Electrocochleography	60.86	60.86
92585	Auditor evoke potent, compre	62.23	62.23
92585-TC	Auditor evoke potent, compre	45.42	45.42
92585-26	Auditor evoke potent, compre	16.81	16.81
92586	Evoked auditory test	45.42	45.42
92587	Evoked otoacoustic emissions; limited	36.79	36.79
92587-TC	Evoked otoacoustic emissions; limited	32.25	32.25
92587-26	Evoked otoacoustic emissions; limited	4.54	4.54
92588	Evoked auditory test	48.37	48.37
92588-TC	Evoked auditory test	36.34	36.34
92588-26	Evoked auditory test	12.04	12.04

Speech Therapy (cont.)

Procedure Code	Brief Description	July 1, 2005 Maximum Allowable Fee	
		Non Facility Setting	Facility Setting
Audiologists Only (cont.)			
92601	Cochlear implt f/up exam < 7	$82.21	$82.21
92602	Reprogram cochlear implt < 7	56.32	56.32
92603	Cochlear implt f/up exam 7 >	50.64	50.64
92604	Reprogram cochlear implt 7 >	32.48	32.48
92620	Auditory function, 60 min	27.48	27.48
92621	Auditory function, + 15 min	6.81	6.81
92625	Tinnitus assessment	27.02	27.02
Speech-Language Pathologist Only			
92526	Oral function therapy	50.87	17.49
92597	Oral speech device eval	59.27	30.43
92605	Eval for nonspeech device rx	Bundled	
92606	Non-speech device service	Bundled	
92607	Ex for speech device rx, 1 hr	71.99	71.99
92608	Ex for speech device rx, addl	13.63	13.63
92609	Use of speech device service	37.47	37.47
92610	Evaluate swallowing function	80.62	80.62

Continued on next page…

OCCUPATIONAL THERAPY

Procedure Code	Brief Description	July 1, 2005 Maximum Allowable Fee	
		Non Facility Setting	Facility Setting
64550	Apply neurostimulator	$10.67	$5.45
97003	OT evaluation	48.83	37.70
97004	OT re-evaluation	29.52	18.40
97110	Therapeutic exercises	16.81	16.81
97112	Neuromuscular reeducation	17.71	17.71
97113	Aquatic therapy/exercises	19.30	19.30
97150	Group therapeutic procedures	10.45	10.45
97504	Orthotic training	18.40	18.40
97520	Prosthetic training	16.81	16.81
97530	Therapeutic activities	17.71	17.71
97532	Cognitive skills development	14.76	14.76
97533	Sensory integration	15.67	15.67
97535	Self-care mngment training	18.17	18.17
97537	Community/work reintegration	16.35	16.35
97703	Prosthetic checkout	15.44	15.44

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Billing

What is the time limit for billing? (Refer to WAC 388-502-0150)

MAA requires providers to submit an initial claim, be assigned an internal control number (ICN), and adjust all claims in a timely manner. MAA has two timeliness standards: 1) for initial claims; and 2) for resubmitted claims.

- **Initial Claims**

  ✓ MAA requires providers to submit an **initial claim** to MAA and obtain an ICN within 365 days from any of the following:

  - The date the provider furnishes the service to the eligible client;
  - The date a final fair hearing decision is entered that impacts the particular claim;
  - The date a court orders MAA to cover the services; or
  - The date DSHS certifies a client eligible under delayed[1] certification criteria.

  ☞ **Note:** If MAA has recouped a plan's premium, causing the provider to bill MAA, the time limit is 365 days from the date the plan recouped the payment from the provider.

  ✓ MAA may grant exceptions to the 365 day time limit for **initial claims** when billing delays are caused by either of the following:

  - DSHS certification of a client for a retroactive[2] period; or
  - The provider proves to MAA's satisfaction that there are other extenuating circumstances.

[1] **Delayed Certification:** A person applies for a medical program prior to the month of service and a delay occurs in the processing of the application. Because of this delay, the eligibility determination date becomes later than the month of service. A delayed certification indicator will appear on the MAID card. The provider **MUST** refund any payment(s) for a covered service received from the client for the period he/she is determined to be medical assistance-eligible, and then bill MAA for those services.

[2] **Retroactive Certification:** An applicant receives a service, then applies to MAA for medical assistance at a later date. Upon approval of the application, the person was found eligible for the medical service at the time he or she received the service. The provider **MAY** refund payment made by the client and then bill MAA for the service. If the client has not paid for the service and the service is within the client's scope of benefits, providers must bill MAA.

- ✓ MAA requires providers to bill known third parties for services. See WAC 388-501-0200 for exceptions. Providers must meet the timely billing standards of the liable third parties, in addition to MAA's billing limits.

- **Resubmitted Claims**

  - ✓ Providers may resubmit, modify, or adjust any timely initial claim for a period of 36 months from the date of service.

  ☞ **Note:** MAA does not accept any claim for resubmission, modification, or adjustment after the allotted time period listed above.

- The allotted time periods do not apply to overpayments that the provider must refund to DSHS. After the allotted time periods, a provider may not refund overpayments to MAA by claim adjustment. The provider must refund overpayments to MAA by a negotiable financial instrument such as a bank check.

- The provider, or any agent of the provider, must not bill a client or a client's estate when:

  - ✓ The provider fails to meet these listed requirements; and
  - ✓ MAA does not pay the claim.

What fee should I bill MAA for eligible clients?

Bill MAA your usual and customary fee**.**

How do I bill for clients eligible for Medicare and Medicaid?

If a client is eligible for both Medicare and Medical Assistance, **you must <u>first</u> submit a claim to Medicare and accept assignment within Medicare's time limitations**. MAA may make an additional payment after Medicare reimburses you.

- If Medicare pays the claim, the provider must bill MAA within six months of the date Medicare processes the claims.

- If Medicare denies payment of the claim, MAA requires the provider to meet MAA's initial 365-day requirement for initial claims.

Medicare Part B

Benefits covered under Part B include: **Physician, outpatient hospital services, home health, durable medical equipment, and other medical services and supplies** not covered under Part A.

When the words *"This information is being sent to either a private insurer or Medicaid fiscal agent,"* appear on your Medicare remittance notice, it means that your claim has been forwarded to MAA or a private insurer for deductible and/or coinsurance processing.

If you have received a payment or denial from Medicare, but it does not appear on your MAA Remittance and Status Report (RA) within 45 days from Medicare's statement date, you should bill MAA directly.

- If Medicare has made payment, and there is a balance due from MAA, you must submit a HCFA-1500 claim form (with the "XO" indicator in field 19). Bill only those lines Medicare paid. Do no submit paid lines with denied lines. This could cause a delay in payment.

- If Medicare denies services, but MAA covers them, you must bill on a HCFA-1500 claim form (without the "XO" indicator in field 19). Bill only those lines Medicare denied. Do not submit denied lines with paid lines. This could cause a delay in payment.

Note: Medicare/Medical Assistance billing claims must be received by MAA within six (6) months of the Medicare EOMB paid date.

Note: A Medicare Remittance Notice or EOMB must be attached to each claim.

Payment Methodology – Part B

- MMIS compares MAA's allowed amount to Medicare's allowed amount and selects the lesser of the two. (If there is no MAA allowed amount, MAA uses Medicare's allowed amount.)

- Medicare's payment is deducted from the amount selected above.

- If there is *no* balance due, the claim is denied because Medicare's payment exceeds MAA's allowable.

- If there *is* a balance due, payment is made towards the deductible and/or coinsurance up to MAA's maximum allowable.

MAA cannot make direct payments to clients to cover the deductible and/or coinsurance amount of Part B Medicare. MAA *can* pay these costs to the provider on behalf of the client when:

1) The provider accepts assignment; and

2) The total combined reimbursement to the provider from Medicare and Medicaid does not exceed Medicare or Medicaid's allowed amount, whichever is less.

Third-Party Liability

You must bill the insurance carrier(s) indicated on the client's MAID card. An insurance carrier's time limit for claim submissions may be different from MAA's. It is your responsibility to meet the insurance carrier's requirements relating to billing time limits, as well as MAA's, prior to any payment by MAA.

You must meet MAA's 365-day billing time limit even if you have not received notification of action from the insurance carrier. If your claim is denied due to any existing third-party liability, refer to the corresponding MAA Remittance and Status Report for insurance information appropriate for the date of service.

If you receive an insurance payment and the carrier pays you less than the maximum amount allowed by MAA, or if you have reason to believe that MAA may make an additional payment:

- Submit a completed claim form to MAA;
- Attach the insurance carrier's statement or EOB;
- If rebilling, also attach a copy of the MAA Remittance and Status Report showing the previous denial; or
- If you are rebilling electronically, list the claim number (ICN) of the previous denial in the Comments field of the Electronic Media Claim (EMC).

Third-party carrier codes are available on MAA's website at http://maa.dshs.wa.gov or by calling the Coordination of Benefits Section at 1-800-562-6136.

What records must be kept? [Refer to WAC 388-502-0020]

Enrolled providers must:

- Keep legible, accurate, and complete charts and records to justify the services provided to each client, including, but not limited to:

  - ✓ Patient's name and date of birth;
  - ✓ Dates of service(s);
  - ✓ Name and title of person performing the service, if other than the billing practitioner;
  - ✓ Chief complaint or reason for each visit;
  - ✓ Pertinent medical history;
  - ✓ Pertinent findings on examination;
  - ✓ Medications, equipment, and/or supplies prescribed or provided;
  - ✓ Description of treatment (when applicable);
  - ✓ Recommendations for additional treatments, procedures, or consultations;
  - ✓ X-rays, tests, and results;
  - ✓ Dental photographs/teeth models;
  - ✓ Plan of treatment and/or care, and outcome; and
  - ✓ Specific claims and payments received for services.

- Assure charts are authenticated by the person who gave the order, provided the care, or performed the observation, examination, assessment, treatment or other service to which the entry pertains.

- **Make charts and records available to DSHS, its contractors, and the US Department of Health and Human Services, upon their request, <u>for six years from the date of service</u> or more if required by federal or state law or regulation.**

How to Complete the HCFA-1500 Claim Form

The HCFA-1500 (U2) (12-90) (Health Insurance Claim Form) is a universal claim form used by many agencies nationwide; a number of the fields on the form do not apply when billing the Medical Assistance Administration (MAA). Some field titles may not reflect their usage for this claim type. The numbered boxes on the claim form are referred to as fields.

General Instructions

- Please use an original, red and white HCFA-1500 (U2) (12-90) claim form.
- Enter only one (1) procedure code per detail line (field 24A-24K). If you need to bill more than six (6) lines per claim, please complete an additional HCFA-1500 claim form.
- You must enter all information within the space allowed.
- Use upper case (capital letters) for all alpha characters.
- Do not write, print, or staple any attachments in the bar area at the top of the form.

FIELD DESCRIPTION

1a. **Insured's I.D. No.**: Required. Enter the MAA Patient (client) Identification Code (PIC) - an alphanumeric code assigned to each Medical Assistance client. This information is obtained from the client's current monthly Medical Assistance IDentification (MAID) card consisting of:

- First and middle initials (a dash [-] *must* be used if the middle initial is not available).
- Six-digit birthdate, consisting of *numerals only* (MMDDYY).
- First five letters of the last name. If there are fewer than five letters in the last name, leave spaces for the remainder before adding the tiebreaker.
- An alpha or numeric character (tiebreaker).

For example:

✓ Mary C. Johnson's PIC looks like this: MC010667JOHNSB.

✓ John Lee's PIC needs two spaces to make up the last name, does not have a middle initial and looks like this: J-100257LEE B.

✓ A PIC for Mary C. Johnson's newborn baby would look like this: MC010667JOHNSB and

- ✓ would show a **B** indicator *in field 19*. If the client is one of twins or triplets, enter **B** and indicate the client on the claim as "twin A or B" or "triplet A, B, or C, " as appropriate.

2. **Patient's Name**: Required. Enter the last name, first name, and middle initial of the MAA client (the receiver of the services for which you are billing).

3. **Patient's Birthdate**: Required. Enter the birthdate of the MAA client.

4. **Insured's Name (Last Name, First Name, Middle Initial)**: When applicable. If the client has health insurance through employment or another source (e.g., private insurance, Federal Health Insurance Benefits, CHAMPUS, or CHAMPVA), list the name of the insured here. Enter the name of the insured except when the insured and the client are the same - then the word *Same* may be entered.

5. **Patient's Address**: Required. Enter the address of the MAA client who has received the services you are billing for (the person whose name is in *field 2*.)

9. **Other Insured's Name**: Secondary insurance. When applicable, enter the last name, first name, and middle initial of the insured. If the client has insurance secondary to the insurance listed in *field 11*, enter it here.

9a. Enter the other insured's policy or group number *and* his/her Social Security Number.

9b. Enter the other insured's date of birth.

9c. Enter the other insured's employer's name or school name.

9d. Enter the insurance plan name or the program name (e.g., the insured's health maintenance organization, private supplementary insurance).

Please note: DSHS, Welfare, Provider Services, Healthy Kids, First Steps, PCCM, Medicare, Indian Health, etc., are inappropriate entries for this field.

10. **Is Patient's Condition Related to**: Required. Check *yes* or *no* to indicate whether employment, auto accident or other accident involvement applies to one or more of the services described in *field 24*. ***Indicate the name of the coverage source in field 10d*** (L&I, name of insurance company, etc.).

11. **Insured's Policy Group or FECA (Federal Employees Compensation Act) Number**: Primary insurance. When applicable. This information applies to the insured person listed in *field 4*. Enter the insured's policy and/or group number and his/her social security number. The data in this field will indicate that the client has other insurance coverage and Medicaid pays as payor of last resort.

11a. **Insured's Date of Birth**: Primary insurance. When applicable, enter the insured's birthdate, if different from *field 3.*

11b. **Employer's Name or School Name**: Primary insurance. When applicable, enter the insured's employer's name or school name.

11c. **Insurance Plan Name or Program Name**: Primary insurance. When applicable, show the insurance plan or program name to identify the primary insurance involved. *(Note: This may or may not be associated with a group plan.)*

11d. **Is There Another Health Benefit Plan?:** Required if the client has secondary insurance. Indicate *yes* or *no*. If yes, you should have completed *fields 9a.-d*. If the client has insurance, and even if you know the insurance will not cover the service you are billing, you must check *yes*.

17. **Name of Referring Physician or Other Source**: When applicable. Enter the referring physician or Primary Care Case Manager name. This field ***must*** be completed for consultations, or for referred laboratory or radiology services (or any other services indicated in your billing instructions as requiring a referral source.)

17a. **I.D. Number of Referring Physician**: Enter the seven-digit, MAA-assigned identification number of the provider who *referred or ordered* the medical service; OR 2) when the Primary Care Case Manager (PCCM) referred the service, enter his/her seven-digit identification number here. If the client is enrolled in a PCCM plan and the PCCM referral number is not in this field when you bill MAA, the claim will be denied.

19. **Reserved for local use**: When applicable, enter additional information such as indicator "**B**" to indicate baby on parent's PIC. If the client is one of twins or triplets, enter **B** and indicate the client on the claim as "twin A or B" or "triplet A, B, or C, " as appropriate.

21. **Diagnosis or Nature of Illness or Injury**: When applicable, enter the appropriate diagnosis code(s) in areas 1, 2, 3, and 4.

22. **Medicaid Resubmission**: When applicable. If this billing is being submitted beyond the 365-day billing time limit, enter the ICN that verifies that your claim was originally submitted within the time limit. (The ICN number is the *claim number* listed on the Remittance and Status Report.)

23. **Prior Authorization Number:** When applicable. If the service you are billing for requires authorization, enter the nine-digit number assigned to you. Only one authorization number is allowed per claim.

24. **Enter only one (1) procedure code per detail line (fields 24A - 24K). If you need to bill more than six (6) lines per claim, please use an additional HCFA-1500 claim form**.

24A. **Date(s) of Service**: Required. Enter the "from" and "to" dates using all six digits for each date. Enter the month, day, and year of service numerically (e.g., September 04, 2000 = 090400).

24B. **Place of Service**: Required. Enter 11 (office or neurodevelopmental center).

24D. **Procedures, Services or Supplies CPT/HCPCS**: Required. Enter the appropriate CPT or HCFA Common Procedure Coding System (HCPCs) procedure code from the fee schedule in these billing instructions for the services being billed.

24E. **Diagnosis Code**: Required. Enter the ICD-9-CM diagnosis code related to the procedure or service being billed (for each item listed in 24D). A diagnosis code is required for each service or line billed. Enter the code exactly as shown in ICD-9-CM.

24F. **$ Charges**: Required. Enter your usual and customary charge for the service performed. Do not include dollar signs or decimals in this field. If more than one unit is being billed, the charge shown must be for the total of the units billed. Do not add sales tax. Sales tax is automatically calculated by the system and included with your remittance amount.

24G. **Days or Units**: Required. Enter the appropriate number of units.

25. **Federal Tax I.D. Number: Leave this field blank.**

26. **Your Patient's Account No.**: Not required. Enter an alphanumeric ID number, i.e., a medical record number or patient account number. This number will be printed on your Remittance and Status Report under the heading *Patient Account Number*.

28. **Total Charge**: Required. Enter the sum of your charges. Do not use dollar signs or decimals in this field.

29. **Amount Paid**: If you receive an insurance payment or client-paid amount, show the amount here, and attach a copy of the insurance EOB. If payment is received from source(s) other than insurance, specify the source in *field 10d*. Do not use dollar signs or decimals in this field or put Medicare payment here.

30. **Balance Due**: Required. Enter balance due. Enter total charges minus any amount(s) in *field 29*. Do not use dollar signs or decimals in this field.

33. **Physician's, Supplier's Billing Name, Address, Zip Code and Telephone Number**: Required. Put the *Name*, *Address*, and *Telephone Number* on all claim forms.

Group: This is the seven-digit number assigned by MAA to a provider group that identifies the entity (e.g., clinic, lab, hospital emergency room, etc.). When a valid group number is entered in this field, payment will be made under this number.

NOTE: Certain group numbers may require a PIN number, in addition to the group number, in order to identify the performing provider.

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

APPROVED OMB-0938-0008

CARRIER

PICA

HEALTH INSURANCE CLAIM FORM

PICA

PATIENT AND INSURED INFORMATION

1. MEDICARE ☐ (Medicare #) MEDICAID ☐ (Medicaid #) CHAMPUS ☐ (Sponsor's SSN) CHAMPVA ☐ (VA File #) GROUP HEALTH PLAN ☐ (SSN or ID) FECA BLK LUNG ☐ (SSN) OTHER ☐ (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M ☐ F ☐

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. PATIENT STATUS Single ☐ Married ☐ Other ☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (INCLUDE AREA CODE) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES ☐ NO ☐

a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. AUTO ACCIDENT? YES ☐ NO ☐ PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES ☐ NO ☐

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES ☐ NO ☐ ***If yes***, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES ☐ NO ☐ $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. _____ . __ 3. _____ . __

2. _____ . __ 4. _____ . __

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1												
2												
3												
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER SSN ☐ EIN ☐

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES ☐ NO ☐

28. $ TOTAL CHARGE

29. $ AMOUNT PAID

30. $ BALANCE DUE

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

PIN# GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

PLEASE PRINT OR TYPE

FORM HCFA-1500 (12-90), FORM RRB-1500, FORM OWCP-1500

Common Questions Regarding Medicare Part B/ Medicaid Crossover Claims

Q: Why do I have to mark "XO," in box 19 on crossover claim?

A: The "XO" allows our mailroom staff to identify crossover claims easily, ensuring accurate processing for payment.

Q: Where do I indicate the coinsurance and deductible?

A: You must enter the total combined coinsurance and deductible in field 24D on each detail line on the claim form.

Q: What fields do I use for HCFA-1500 Medicare information?

A:

In Field:	**Please Enter:**
19	an "XO"
24D	total combined coinsurance and deductible
24K	Medicare's allowed charges
29	Medicare's total deductible
30	Medicare's total payment
32	Medicare's EOMB process date, and the third-party liability amount

Q: When I bill Medicare denied lines to MAA, why is the claim denied?

A: Your bill is not a crossover when Medicare denies your claim or if you are billing for Medicare-denied lines. The Medicare EOMB must be attached to the claim. Do not indicate "XO."

Q: How do my claims reach MAA?

A: After Medicare has processed your claim, and if Medicare has allowed the services, in most cases Medicare will forward the claim to MAA for any supplemental Medicaid payment. When the words, *"This information is being sent to either a private insurer or Medicaid fiscal agent,"* appear on your Medicare remittance notice, it means that your claim has been forwarded to MAA or a private insurer.

If **Medicare has paid** and the Medicare crossover claim does not appear on the MAA Remittance and Status Report within 30 days of the Medicare statement date, you should bill MAA on the HCFA-1500 claim form.

If **Medicare denies** a service, bill MAA using the HCFA-1500 claim form. Be sure the Medicare denial letter or EOMB is attached to your claim to avoid delayed or denied payment due to late submission.

REMEMBER! You must submit your claim to MAA within six months of the Medicare statement date if Medicare has paid or 365 days from date of service if Medicare has denied.

How to Complete the HCFA-1500 Claim Form for Medicare Part B/Medicaid Crossovers

The HCFA-1500 (U2) (12-90) (Health Insurance Claim Form) is a universal claim form used by many agencies nationwide; a number of the fields on the form do not apply when billing the Medical Assistance Administration (MAA). Some field titles may not reflect their usage for this claim type. The numbered boxes on the claim form are referred to as fields.

General Instructions

- Please use an original, red and white HCFA-1500 (U2) (12-90) claim form.
- Enter only one (1) procedure code per detail line (field 24A-24K). If you need to bill more than six (6) lines per claim, please complete an additional HCFA-1500 claim form.
- You must enter all information within the space allowed.
- Use upper case (capital letters) for all alpha characters.
- Do not write, print, or staple any attachments in the bar area at the top of the form.

FIELD DESCRIPTION

1a. **Insured's I.D. No.:** Required. Enter the MAA Patient Identification Code (PIC) - an alphanumeric code assigned to each Medical Assistance client. This information is obtained from the client's current Medical Assistance Identification (MAID) card consisting of:

- First and middle initials (a dash [-] *must* be used if the middle initial is not available).
- Six-digit birthdate, consisting of *numerals only* (MMDDYY).
- First five letters of the last name. If there are fewer than five letters in the last name, leave spaces for the remainder before adding the tiebreaker.
- An alpha or numeric character (tiebreaker).

For example:

- ✓ Mary C. Johnson's PIC looks like this: MC010633JOHNSB.
- ✓ John Lee's PIC needs two spaces to make up the last name, does not have a middle initial and looks like this: J-100226LEE B.

2. **Patient's Name:** Required. Enter the last name, first name, and middle initial of the MAA client (the receiver of the services for which you are billing).

3. **Patient's Birthdate:** Required. Enter the birthdate of the MAA client.

4. **Insured's Name (Last Name, First Name, Middle Initial):** When applicable. If the client has health insurance through employment or another source (e.g., private insurance, Federal Health Insurance Benefits, CHAMPUS, or CHAMPVA), list the name of the insured here. Enter the name of the insured except when the insured and the client are the same - then the word *Same* may be entered.

5. **Patient's Address:** Required. Enter the address of the MAA client who has received the services you are billing for (the person whose name is in *field 2*).

9. **Other Insured's Name:** Secondary insurance. When applicable, enter the last name, first name, and middle initial of the insured. If the client has insurance secondary to the insurance listed in *field 11*, enter it here.

9a. Enter the other insured's policy or group number *and* his/her Social Security Number.

9b. Enter the other insured's date of birth.

9c. Enter the other insured's employer's name or school name.

9d. Enter the insurance plan name or the program name (e.g., the insured's health maintenance organization, or private supplementary insurance).

Please note: DSHS, Welfare, Provider Services, Healthy Kids, First Steps, Medicare, Indian Health, PCCM, Healthy Options, PCOP, etc., are inappropriate entries for this field.

10. **Is Patient's Condition Related To:** Required. Check *yes* or *no* to indicate whether employment, auto accident or other accident involvement applies to one or more of the services described in *field 24*. ***Indicate the name of the coverage source in field 10d*** (L&I, name of insurance company, etc.).

11. **Insured's Policy Group or FECA (Federal Employees Compensation Act) Number:** Primary insurance. When applicable. This information applies to the insured person listed in *field 4*. Enter the insured's policy and/or group number and his/her social security number. The data in this field will indicate that the client has other insurance coverage and Medicaid pays as payor of last resort.

11a. **Insured's Date of Birth:** Primary insurance. When applicable, enter the insured's birthdate, if different from *field 3*.

11b. **Employer's Name or School Name:** Primary insurance. When applicable, enter the insured's employer's name or school name.

11c. **Insurance Plan Name or Program Name:** Primary insurance. When applicable, show the insurance plan or program name to identify the primary insurance involved. *(Note: This may or may not be associated with a group plan.)*

11d. **Is There Another Health Benefit Plan?:** Required if the client has secondary insurance. Indicate *yes* or *no*. If yes, you should have completed *fields 9a.-d*. If the client has insurance, and even if you know the insurance will not cover the service you are billing, you must check *yes*.

19. **Reserved For Local Use: Required. When Medicare allows services, enter *XO* to indicate this is a crossover claim.**

22. **Medicaid Resubmission:** When applicable. If this billing is being resubmitted more than six (6) months from Medicare's paid date, enter the Internal Control Number (ICN) that verifies that your claim was originally submitted within the time limit. (The ICN number is the *claim number* listed on the Remittance and Status Report.) Also enter the three-digit denial Explanation of Benefits (EOB).

24. **Enter only one (1) procedure code per detail line (fields 24A - 24K). If you need to bill more than six (6) lines per claim, please use an additional HCFA-1500 claim form.**

24A. **Date(s) of Service:** Required. Enter the "from" and "to" dates using all six digits for each date. Enter the month, day, and year of service numerically (e.g., September 4, 2000 = 090400). **Do not use slashes, dashes, or hyphens to separate month, day or year (MMDDYY).**

24B. **Place of Service:** Required. Enter a 11.

24D. **Procedures, Services or Supplies CPT/HCPCS: Required. Coinsurance and Deductible:** Enter the total combined and deductible for each service in the space to the right of the modifier on each detail line.

24E. **Diagnosis Code:** Enter the ICD-9-CM diagnosis code related to the procedure or service being billed. Enter the code exactly as shown in ICD-9-CM.

24F. **$ Charges:** Required. Enter the amount you billed Medicare for the service performed. If more than one unit is being billed, the charge shown must be for the total of the units billed. Do not include dollar signs or decimals in this field. Do not add sales tax.

24G. **Days Or Units:** Required. Enter appropriate number of units.

24K. **Reserved for Local Use:** Required. Use this field to show Medicare allowed charges. Enter the Medicare allowed charge on each detail line of the claim (see sample).

26. **Your Patient's Account No.:** Not required. Enter an alphanumeric ID number, for example, a medical record number or patient account number. This number will be printed on your Remittance and Status Report under the heading *Patient Account Number*.

27. **Accept Assignment:** ***Required.*** Check **yes**.

28. **Total Charge:** Required. Enter the sum of your charges. Do not use dollar signs or decimals in this field.

29. **Amount Paid:** Required. Enter the Medicare Deductible here. Enter the amount as shown on Medicare's Remittance Notice and Explanation of Benefits. If you have more than six (6) detail lines to submit, please use multiple HCFA-1500 claim forms (see field 24) and calculate the deductible based on the lines on each form. **Do not include coinsurance here.**

30. **Balance Due:** Required. Enter the Medicare Total Payment. Enter the amount as shown on Medicare's Remittance Notice or Explanation of Benefits. If you have more than six (6) detail lines to submit, please use multiple HCFA claim forms (see field 24) and calculate the Medicare payment based on the lines on each form. **Do not include coinsurance here.**

32. **Name and Address of Facility Where Services Are Rendered:** Required. Enter Medicare Statement Date *and* any Third-Party Liability Dollar Amount (e.g., auto, employee-sponsored, supplemental insurance) here, if any. If there is insurance payment on the claim, you must also attach the insurance Explanation of Benefits (EOB). **Do not include coinsurance here.**

33. **Physician's, Supplier's Billing Name, Address, Zip Code and Phone #:** Required. Put the *Name*, *Address*, and *Telephone Number* on all claim forms.

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

APPROVED OMB-0938-0008

CARRIER

PICA

HEALTH INSURANCE CLAIM FORM

PICA

PATIENT AND INSURED INFORMATION

1. MEDICARE ☐ (Medicare #) MEDICAID ☐ (Medicaid #) CHAMPUS ☐ (Sponsor's SSN) CHAMPVA ☐ (VA File #) GROUP HEALTH PLAN ☐ (SSN or ID) FECA BLK LUNG ☐ (SSN) OTHER ☐ (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M ☐ F ☐

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. PATIENT STATUS Single ☐ Married ☐ Other ☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (INCLUDE AREA CODE) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES ☐ NO ☐

a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. AUTO ACCIDENT? YES ☐ NO ☐ PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES ☐ NO ☐

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES ☐ NO ☐ ***If yes***, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES ☐ NO ☐ $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. _____ . __ 3. _____ . __

2. _____ . __ 4. _____ . __

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1												
2												
3												
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER SSN ☐ EIN ☐

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES ☐ NO ☐

28. $ TOTAL CHARGE

29. $ AMOUNT PAID

30. $ BALANCE DUE

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

PIN# GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

PLEASE PRINT OR TYPE

FORM HCFA-1500 (12-90), FORM RRB-1500, FORM OWCP-1500

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

APPROVED OMB-0938-0008

CARRIER

PICA

HEALTH INSURANCE CLAIM FORM

PICA

PATIENT AND INSURED INFORMATION

1. MEDICARE ☐ (Medicare #) MEDICAID ☐ (Medicaid #) CHAMPUS ☐ (Sponsor's SSN) CHAMPVA ☐ (VA File #) GROUP HEALTH PLAN ☐ (SSN or ID) FECA BLK LUNG ☐ (SSN) OTHER ☐ (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M ☐ F ☐

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. PATIENT STATUS Single ☐ Married ☐ Other ☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (INCLUDE AREA CODE) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES ☐ NO ☐

a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. AUTO ACCIDENT? YES ☐ NO ☐ PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES ☐ NO ☐

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES ☐ NO ☐ ***If yes***, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES ☐ NO ☐ $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. _____ . __ 3. _____ . __

2. _____ . __ 4. _____ . __

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1												
2												
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4												
5												
6												

25. FEDERAL TAX I.D. NUMBER SSN ☐ EIN ☐

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES ☐ NO ☐

28. $ TOTAL CHARGE

29. $ AMOUNT PAID

30. $ BALANCE DUE

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

PIN# GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

PLEASE PRINT OR TYPE

FORM HCFA-1500 (12-90), FORM RRB-1500, FORM OWCP-1500